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## DEPARTMENT OF VETERANS AFFAIRS

# Key Management Challenges in Health and Disability Programs

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Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss our past and current work on veterans' health care and disability benefits—two major program areas at the Department of Veterans Affairs (VA). As you know, VA's budget submission for fiscal year 2004 includes about \$64 billion and 214,000 staff. In fiscal year 2002, VA spent about \$23 billion to provide health care to over 4 million veterans and about \$26 billion to provide cash disability benefits to over 3 million veterans, family members, and survivors.

It is especially fitting, with the recent deployment of our military forces to armed conflict, that we reaffirm our commitment to provide high quality services in a convenient and timely manner to those who serve our nation in its times of need. Meeting this commitment as efficiently and effectively as possible is also of paramount importance. In this regard, my statement focuses on challenges that VA faces to ensure reasonable access to health care, use its health care resources efficiently, and manage its disability programs effectively.

My comments today are based on numerous reports and testimonies issued over the last 7 years, including significant recommendations we have made and VA's progress in implementing them. (See Related GAO Products.) We did our work in over 100 VA health care delivery locations and conducted surveys of all 21 health care networks and reviews of disability management issues covering all 57 disability claims processing regional offices. We are also reporting preliminary results of ongoing health care work that started in November 2002. This involves visits to delivery locations, document reviews and interviews with VA officials in headquarters and the networks. We did our work in accordance with generally accepted government auditing standards.

In summary, VA is challenged to meet the acute and nursing home care needs of veterans in a timely, convenient, and equitable manner. Despite VA's significant access enhancements over the past several years, too many veterans continue to travel too far and wait too long for appointments, especially when they require hospital admissions or

consultations with specialists on an outpatient basis. When trying to reduce travel times, VA faces difficult decisions because shifting care closer to where veterans live can have significant ramifications for stakeholders, such as medical schools, as well as for the use of VA's existing resources. In addition, VA's efforts to reduce waiting times may be complicated by an anticipated surge in demand for VA specialty outpatient care over the next 10 years. Also, the population most in need of nursing home care—veterans who are 85 years old or older—is growing. As a result, VA faces difficult decisions concerning the delivery and sizing of nursing home-term care services to equitably meet these needs.

VA is also challenged to find ways to use available health care resources more efficiently to meet veterans' demand for health care. For example, VA operates and maintains a large portfolio of aged health care assets, primarily buildings, which reflects a business model and technological environment of the 1950s. This infrastructure is no longer effectively aligned with VA's new delivery model that emphasizes outpatient care. As a result, VA faces difficult realignment decisions involving capital investments, consolidations, closures, and contracting with local providers. These may have significant ramifications for stakeholders, such as medical schools and unions, primarily because realignments involve a shifting of workload among delivery locations or workforce reductions. VA also faces challenges in implementing management changes to improve the efficiency of patient support services, such as food and laundry services.

In addition, VA is challenged to find ways to compensate disabled veterans in a more meaningful and timely manner. For example, VA uses a disability determination process that is based on economic conditions in 1945 and, as such, does not accurately reflect current relationships between impairments and the skills and abilities needed to work in today's business environment. Moreover, the consequences of some medical conditions for many individuals have been reduced through advances in medicine and technology, which allow individuals to live with greater independence and function more effectively in work settings. Besides modernizing the economic and medical underpinnings of the program, VA remains in the midst of significant challenges to improve the quality, timeliness, and consistency of disability claims processing. Despite its recent efforts, too

many disabled veterans wait too long for disability decisions. Significant and sustainable improvements may not be possible without fundamental program design changes, including those that require legislative actions to implement. VA and the Congress could face significant stakeholder resistance to such changes.

I would also like to point out that we designated federal real property and federal disability programs as high-risk areas in January 2003.<sup>1</sup> We did this to draw attention to the need for broad-based transformation in these areas, which is critical to improving the government's performance and ensuring accountability within expected resource limits. If this transformation is well implemented, agencies will be better positioned to achieve mission effectiveness, reduce operating costs, improve facility conditions, and enhance security and safety.

## **BACKGROUND**

During World War I, Public Health Service hospitals treated returning veterans and, at the end of the war, several military hospitals were transferred to the Public Health Service to enable it to continue treating injured soldiers. In 1921, those hospitals were transferred to the newly established Veterans' Bureau. By the early 1990s, the veterans' health care system had grown into one of our nation's largest direct providers of health care, comprising more than 172 hospitals.

In October 1995, VA began to transform its health care system from a hospital-dominated model to one that provides a full range of health care services. A key feature of this transformation involves the development of community-based, integrated networks of VA and non-VA providers that could deliver health care closer to where veterans live. At that time, about half of all veterans lived more than 25 miles from a VA hospital; about 44 percent of those admitted to VA hospitals lived more than 25 miles away.<sup>2</sup> In making

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<sup>1</sup> U.S. General Accounting Office, *High-Risk Series: An Update*, GAO-03-119 (Washington, D.C.: Jan. 2003); *High-Risk Series: Federal Real Property*, GAO-03-122 (Washington, D.C.: Jan. 2003).

<sup>2</sup> U.S. General Accounting Office, *VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services* GAO/HEHS-96-31 (Washington, D.C.: Dec. 20, 1995).

care more proximate to veterans' homes, VA also began shifting the delivery of health care from high-cost hospital settings to lower-cost outpatient settings.

To facilitate VA's transformation, the Congress passed the Veterans' Health Care Eligibility Reform Act of 1996, which furnishes tools that VA said were key to a successful transformation, including:

- new eligibility rules that allow VA to treat veterans in the most appropriate setting;
- a uniform benefits package to provide a continuum of services; and
- an expanded ability to purchase services from private providers.

Today, VA operates over 800 delivery locations nationwide, including over 600 community-based outpatient clinics and 162 hospitals. VA's delivery locations are organized into 21 geographic areas, commonly referred to as networks. Each network includes a management office responsible for making basic budgetary, planning, and operating decisions concerning the delivery of health care to its veterans. Each office oversees between 5 and 11 hospitals, as well as many community-based outpatient clinics.

To promote more cost-effective use of resources, VA is authorized to share resources with other federal agencies to avoid unnecessary duplication and overlap of activities. VA and the Department of Defense (DOD) have entered into agreements to exchange inpatient, outpatient, and specialty care services as well as support services. Local facilities also have arranged to jointly purchase pharmaceuticals, laboratory services, medical supplies, and equipment.

Also, VA has been authorized to enter into agreements with medical schools and their teaching hospitals. Under these agreements, VA hospitals provide training for medical residents, and appoint medical school faculty as VA staff physicians to supervise resident education and patient care. Currently, about 120 medical schools and teaching hospitals

have affiliation agreements with VA. About 28,000 medical residents receive some of their training in VA facilities every year.

Veterans' eligibility for health care also has evolved over time. Before 1924, VA health care was available only to veterans who had wounds or diseases incurred during military service. Eligibility for hospital care was gradually extended to war-time veterans with lower incomes and, in 1973, to peace time veterans with lower incomes. By 1986, all veterans were eligible for hospital and outpatient care for service-connected conditions as well as for conditions unrelated to military service.<sup>3</sup>

VA implemented an enrollment process in 1998 that was established primarily as a means of prioritizing care if sufficient resources were not available to serve all veterans seeking care. About 6.2 million veterans had enrolled by the end of fiscal year 2002. In contrast, the overall veteran population is estimated to be about 25 million. VA projects a decline in the total veteran population over the next 20 years while the enrolled population is expected to decline more slowly as shown in table 1.

Table 1: Veteran Population and Enrollment Projections between Fiscal Years 2007 and 2022 (in millions)

	2007	2012	2017	2022
Veteran Population	22.8	20.6	18.6	16.9
Enrollment	6.3	6.3	6.1	5.7

Source: VA

<sup>3</sup> U.S. General Accounting, Office, *VA Health Care: Issues Affecting Eligibility Reform Efforts*, GAO/HEHS-96-160. (Washington, D.C.: Sept. 11, 1996).

In addition to health care, VA provides disability benefits to those veterans with service-connected conditions. Also, VA provides pension benefits to low-income wartime veterans with permanent and total disabilities unrelated to military service. Further, VA provides compensation to survivors of service members who died while on active duty.

Disabled veterans are entitled to cash benefits whether or not employed and regardless of the amount of income earned. The cash benefit level is based on the percentage evaluation, commonly called the “disability rating,” that represents the average loss in earning capacity associated with the severity of physical and mental conditions. VA uses its *Schedule for Rating Disabilities* to determine which disability rating to assign to a veteran’s particular condition. VA’s ratings are in 10-percent increments, from 0 to 100 percent.

Although VA generally does not pay disability compensation for disabilities rated at 0 percent, such a rating would make veterans eligible for other benefits, including health care. About 65 percent of veterans receiving disability compensation have disabilities rated at 30 percent or lower; about 8 percent are 100 percent disabled. Basic monthly payments range from \$104 for a 10 percent disability to \$2,193 for a 100 percent disability.

To process claims for these benefits, VA operates 57 regional offices. These offices made almost 800,000 rating-related decisions<sup>4</sup> in fiscal year 2002. Regional office personnel develop claims, obtain the necessary information to evaluate claims, and determine whether to grant benefits. In doing so, they consider veterans’ military service records, medical examination and treatment records from VA health care facilities, and treatment records from private providers. Once claims are developed, the claimed disabilities are evaluated, and ratings are assigned based on degree of disability. Veterans with multiple disabilities receive a single, composite rating. For veterans claiming pension eligibility,

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<sup>4</sup> Rating-related claims are primarily original claims for compensation and pension benefits and “reopened” claims, in which veterans claim that a service-connected claim has worsened.

the regional office also determines if the veteran served in a period of war, is permanently and totally disabled for reasons unrelated to military service, and meets the income thresholds for eligibility.

## **ACCESS TO HEALTH CARE COULD BE ENHANCED**

Over the past several years, VA has done much to ensure that veterans have greater access to health care. Despite this, travel times and waiting times are still problems. Another problem faced by aging veterans is potentially inequitable access to nursing home care.

### **Many Veterans Travel Too Far for Hospital Admissions and Specialty Consultations**

The substantial increase in VA health care delivery locations has enhanced access for enrolled veterans in need of primary care, although many still travel long distances for primary care.<sup>5</sup> In addition, many who need to consult with specialists or require hospitalization often travel long distances to receive care. Nationwide, for example, more than 25 percent of veterans enrolled in VA health care--over 1.7 million--live over 60 minutes driving time from a VA hospital. These veterans would have to travel a long distance if they require admissions or consultations with specialists, such as urologists or cardiologists.

In October 2000, VA established the Capital Asset Realignment for Enhanced Services (CARES) program, which has a goal of improving veterans' access to acute inpatient care, primary care, and specialty care. CARES is intended to identify how well the geographic distribution of VA health care resources matches projected needs and the shifts necessary to better align resources and needs. Toward that end, VA has divided,

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<sup>5</sup>U.S. General Accounting Office, *VA Health Care: Community-Based Clinics Improve Primary Care Access*, GAO-01-678T (Washington, D.C.: May 2, 2001).

for analytical purposes, its 21 networks into 76 geographic areas -- groups of counties -- in order to determine the extent to which enrollees' travel times exceed VA's access standards.

For example, as part of CARES, VA has mandated the 21 network directors to identify ways to ensure that at least 65 percent of the veterans in their areas are within VA's access standards for hospital care—60 minutes for veterans residing in urban counties, 90 minutes for those in rural counties, and 120 minutes for those in highly rural counties. VA has identified 25 areas that do not meet this 65 percent target. In these areas, over 900,000 enrolled veterans have travel times that exceed VA's access standards. In addition, as part of CARES, VA identified 51 other areas where access enhancements may be addressed at the discretion of network directors, given that at least 65 percent of all enrolled veterans in those areas have travel times that meet VA's standard. In these areas, about 875,000 enrolled veterans have travel times that exceed VA's standards.

By contrast, VA has not mandated that network directors enhance access for veterans who travel long distances to consult with specialists. Unlike hospital care, VA has not established standards for acceptable travel times for specialty care. Currently, nearly 2 million enrolled veterans live more than 60 minutes driving time from specialists at the closest VA delivery locations.

When considering ways to enhance access for veterans, VA network directors may consider three basic options: construct a new VA-owned and operated delivery location; negotiate a sharing agreement with another federal entity, such as a DOD facility; or contract with nonfederal health care providers. Shifting the delivery of health care closer to where veterans live can have significant ramifications for other stakeholders, such as medical schools. For example, within the 76 areas, there are smaller geographic areas that contain large concentrations of enrollees outside VA's access standards—10,000 or more—who live closer to non-VA hospitals than they do to the nearest VA hospitals. Such enrolled veterans could account for significant portions of the hospital workload at the nearest VA delivery locations. Therefore, a shifting of this workload closer to

veterans' residences could reduce the size of residency training opportunities at existing VA delivery locations.

Enhancing veterans' access can also have significant ramifications regarding the use of VA's existing resources. Currently, VA has most of its resources dedicated to costs associated with its existing hospitals and other infrastructure, including clinical and support staff, at its major health care delivery locations. Reducing veterans' travel times through contracting with providers in local communities or other options would reduce demand for services at VA's existing, more distant delivery locations. Efficient operation of those locations would become more difficult given the smaller workloads in relation to the operating costs of existing hospitals.

### **Many Veterans Wait Too Long for Appointments**

We also have found that excessive waiting times for VA outpatient care persist—a situation that we have reported on for the last decade. For example, in May 2000, we reported that veterans frequently wait longer than 30 days—VA's access standard—for appointments with specialists at VA delivery locations in Florida and other areas of the country.<sup>6</sup> More recently, a Presidential task force reported in its July 2002 interim report that veterans are finding it increasingly difficult to gain access to VA care in selected geographic regions.<sup>7</sup> For example, the task force found that the average waiting time for a first outpatient appointment in Florida, which has a large and growing veteran population, is over a year.

Although there is general consensus that waiting times are excessive, we reported, and VA agreed, that its data did not reliably measure the scope of the problem.<sup>8</sup> To improve

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<sup>6</sup>U.S. General Accounting Office, *VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress*, GAO-01-953 (Washington, D.C.: Aug. 31, 2001).

<sup>7</sup>*President's Task Force to Improve Health Care Delivery for Our Nation's Veteran: Interim Report*, (Washington, D.C.: July 31, 2002).

<sup>8</sup>U.S. General Accounting Office, *Veterans' Health Care: VA Needs Better Data on Extent and Causes of Waiting Times*, GAO/HEHS-00-90 (Washington, D.C.: May 31, 2000).

its data, VA is in the process of developing an automated system to more systematically measure waiting times. VA has also taken several actions to mitigate the impact of long waiting times, including limiting enrollment of lower priority veterans and granting priority for appointments to certain veterans with service-connected disabilities.<sup>9</sup>

VA faces an impending challenge, however, reducing the length of times veterans wait for appointments. Specifically, VA's current projections of acute health care workload indicate a surge in demand for acute health care services over the next 10 years. For example, specialty outpatient demand nationwide is expected to almost double by fiscal year 2012.

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<sup>9</sup> The Veterans' Health Care Eligibility Reform Act of 1996 required VA to establish priority categories for enrollment to manage access in relation to available resources. VA has 8 priority categories, with Priority 1 veterans—those with service-connected disabilities rated 50 percent or more—having the highest priority for enrollment. By contrast, Priority 8 veterans are primarily veterans with no service-connected disabilities and higher incomes.

## Veterans' Access to Nursing Home Care May Be Inequitable

VA's long-term care infrastructure, including nursing homes it operates, was developed when the concentration of veteran population was distributed differently by region. Consequently, the location of VA's current infrastructure may not provide equitable access across the country. In addition, when VA developed its long-term care infrastructure, it relied more on nursing home care and less on home and community-based services than current practice. To help update VA's long-term care policy, the Federal Advisory Committee on the Future of VA Long-Term Care recommended in 1998 that VA maintain its nursing home capacity at the level of that time but meet the growing veteran demand for long term care by greatly expanding home and community-based service capacity.<sup>10</sup> The House Committee on Veterans Affairs' has expressed concern that VA needs to maintain its nursing home capacity workload at 1998 levels.

VA currently operates its own nursing home care units in 131 locations, according to VA headquarters officials. In addition, it pays for nursing home care under contract in community nursing homes. VA also pays part of the cost of care for veterans at state veterans' nursing homes and in addition pays a portion of the construction costs for some state veterans' nursing homes. In all these settings combined, VA's nursing home—average daily census—has declined by more than 1,800 since 1998. See table 2. The biggest decline has been in community nursing home care where the average daily census was 31 percent less in 2002 than in 1998. Average daily census in VA-operated nursing homes also declined by 11 percent during this period. A 9 percent increase in state veterans' home average daily census offsets some of the decline in average daily census in community and VA-operated nursing homes.

Table 2: Nursing Home Average Daily Census Provided or Paid for by VA in Fiscal Years 1998-2002

Type of nursing home	1998	1999	2000	2001	2002
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<sup>10</sup> *VA Long-Term Care At The Crossroads: Report of the Federal Advisory Committee on the Future of VA Long-Term Care*, (Washington, D.C.: June, 1998).

<b>Type of nursing home</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>
VA Nursing Homes	13,426	12,653	11,828	11,674	11,974
Community Nursing Homes	5,575	4,547	3,682	4,010	3,831
State Veterans' Nursing Homes	14,602	15,051	15,286	15,593	15,941
<b>Total</b>	<b>33,603</b>	<b>32,251</b>	<b>30,796</b>	<b>31,277</b>	<b>31,746</b>

Source: VA.

Note: The average daily census represents the total number of days of nursing home care divided by the number of days in the year.

VA headquarters officials told us that the decline in nursing home average daily census could be the result of a number of factors. These factors include providing more emphasis on shorter-term care for post-acute care rehabilitation, providing more home and community-based services to obviate the need for nursing home care, assisting veterans to obtain placement in community nursing homes where care is financed by other payers, such as Medicaid, when appropriate, and difficulty recruiting enough nursing staff to operate all beds in some VA-operated nursing homes.

VA policy provides networks broad discretion in deciding what nursing home care to offer those patients that VA is not required to provide nursing home care to under the provisions of the Veterans Millennium Health Care and Benefits Act of 1999.<sup>11</sup> Networks' use of this discretion appears to result in inequitable access to nursing home care. For example, some networks have policies to provide long-term nursing home care to these veterans who need such care if resources allow, while other networks do not have such policies. As a result, these veterans who need long-term nursing home care may have access to that care in some networks but not others. This is significant because

<sup>11</sup> This act requires that VA provide nursing home care to veterans with service-connected disabilities of 70 percent or more and those who need such care because of a service-connected disability. This provision of the act expires on December 31, 2003.

about two-thirds of VA's current nursing home users are recipients of discretionary nursing home care.

VA intended to address veterans' access to nursing home care as part of its larger CARES initiative to project future health care needs and determine how to ensure equitable access. However, initial projections of nursing home need exceeded VA's current nursing home capacity. VA said that the projections did not reflect its long-term care policy and decided not to include nursing home care in its CARES initiative. Instead, VA officials told us that they have developed a separate process to provide projections for nursing home, and home and community-based services needs. These officials expect that new projections will be developed for consideration by the Under Secretary for Health by July 2003. VA officials also told us that VA will use this information in its strategic planning initiatives to address nursing home and other long-term care issues at the same time that VA implements its CARES initiatives.

Because VA has not systematically examined its nursing home policies and access to care, veterans have no assurance that VA's \$2 billion nursing home program is providing equitable access to care to those who need it. This is particularly important given the aging of the veteran population. The veteran population most in need of nursing home care—veterans 85 years old or older—is expected to increase from almost 640,000 to over 1 million by 2012 and remain at about that level through 2023. Until VA develops a long-term care projection model consistent with its policy, VA will not be able to determine if its nursing home care units in 131 locations and other nursing home care services it pays for provide equitable access to veterans now or in the future.

## **EFFICIENCY COULD BE IMPROVED THROUGH HEALTH CARE ASSET REALIGNMENT AND OTHER MANAGEMENT ACTIONS**

In recent years, VA has made an effort to align its capital assets, primarily buildings, to better serve veterans' needs as well as institute other needed efficiencies. Despite this, many of VA's buildings remain underutilized and support services are not always

provided efficiently. VA could make better use of its resources by taking steps to partner with other public and private providers, purchase care from such providers, replace obsolete assets with modern ones, or consolidate duplicative care provided by multiple locations serving the same geographic areas where it would be cost effective to do so, and assess various management options to improve the efficiency of patient support services.

### **Capital Assets Not Well-Aligned to Meet Veterans' Needs**

VA has a large and aged infrastructure, which is not well aligned to efficiently meet veterans' needs. In recent years, as a result of new technology and treatment methods, VA has shifted delivery from inpatient to outpatient settings in many instances and shortened lengths of stay when hospitalization was required. Consequently, VA has excess inpatient capacity at many locations.

For example, in August 1999, we reported that VA owned about 4,700 buildings, over 40 percent of which had operated for more than 50 years, and almost 200 of which were built before 1900. Many organizations in the facilities management environment consider 40 to 50 years to be the useful life of a building.<sup>12</sup> Moreover, VA used fewer than 1,200 of these buildings (about one-fourth of the total) to deliver health care services to veterans. The rest were used primarily to support health care activities, although many had tenants or were vacant.<sup>13</sup> In addition, most delivery locations had mission-critical buildings that VA considered functionally obsolete. These included, for example, inpatient rooms not up to industry standards concerning patient privacy; outpatient clinics with undersized examination rooms; and buildings with safety concerns, such as vulnerability to earthquakes.

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<sup>12</sup> Price Waterhouse, *Independent Review of the Department of Veterans Affairs' Office of Facilities Management* (Washington, D.C.: June 17, 1998).

<sup>13</sup> Health care support buildings include warehouses, engineering shops, laundries, fire stations, day care centers and boiler plants.

As part of VA's transformation, begun in 1995, its networks implemented hundreds of management initiatives that significantly enhanced their overall efficiency and effectiveness.<sup>14</sup> The success of these strategies—shifting inpatient care to more appropriate settings, establishing primary care in community clinics, and consolidating services in order to achieve economies of scale—significantly reduced utilization at most of VA's inpatient delivery locations. For example, VA operated about 73,000 hospital beds in fiscal year 1995. In fiscal year 1998, veterans used on average fewer than 40,000 hospital beds per day, and by 2001 usage had further declined to about 16,000 hospital beds per day.

In 1999, we concluded that VA's existing infrastructure could be the biggest obstacle confronting VA's ongoing transformation efforts.<sup>15</sup> During a hearing in 1999 before this Committee's Subcommittee on Health, we pointed out that, although VA was addressing some realignment issues, it did not have a plan in place to identify buildings that are no longer needed to meet veterans health care needs. We recommended that VA develop a market-based plan for restructuring its delivery of health care in order to reduce funds spent on underutilized or inefficient buildings. In turn those funds could be reinvested to better serve veterans' needs by placing health care resources closer to where they live.

To do so, we recommended that VA comply with guidance from the Office of Management and Budget. The guidance suggested that market-based assessments include (1) assessing a target population's needs, (2) evaluating the capacity of existing assets, (3) identifying any performance gaps (excesses or deficiencies), (4) estimating assets' life cycle costs, and (5) comparing such costs to other alternatives for meeting the target population's needs. Alternatives include (1) partnering with other public or private providers; (2) purchasing care from such providers; (3) replacing obsolete assets with modern ones; or (4) consolidating services duplicated at multiple locations serving the same market.

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<sup>14</sup>U.S. General Accounting Office, *Veterans' Affairs: Progress and Challenges in Transforming Health Care*, GAO/T-HEHS-99-109 (Washington, D.C.: April 15, 1999).

During the 1999 hearing, the subcommittee chairman urged VA to implement our recommendations and VA agreed to do so. In August 2002, VA announced the results of a pilot study in its Great Lakes network, which includes Chicago and other locations. VA selected three realignment strategies in this network – consolidation of services at existing locations, opening of new outpatient clinics, and closure of one inpatient location. Currently, VA is analyzing ways to realign health care delivery in its 20 remaining networks. VA expects to issue its plans by the end of 2003. To date, VA has projected veterans’ demand for acute health care services through fiscal year 2022, evaluated available capacity at its existing delivery locations, and targeted geographic areas where alternative delivery strategies could allow VA to operate more efficiently and effectively while ensuring access consistent with its standards for travel time.

For example, VA has the opportunity to achieve efficiencies through economies of scale in 30 geographic areas where two or more major health care delivery locations that are in close proximity provide duplicative inpatient and outpatient health care services. VA may also achieve similar efficiencies in 38 geographic areas where two or more tertiary care delivery locations are in close proximity. VA considers delivery locations to be in close proximity if they are within 60 miles of one another for acute care and within 120 miles for tertiary care. In addition, VA may achieve additional efficiencies in 28 geographic areas where existing delivery locations have low acute medicine workloads, which VA has defined as serving less than 40 hospital patients per day. VA also identified more than 60 opportunities for partnering with the DOD to better align the infrastructure of both agencies.<sup>16</sup>

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<sup>15</sup> U.S. General Accounting Office, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83 (Washington, D.C.: Mar. 10, 1999).

<sup>16</sup> In May 2000, we reported that most VA/DOD sharing activity involved a relatively small number of sharing agreements and joint ventures. U.S. General Accounting Office, *VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies*, GAO/HEHS-00-52 (Washington, D.C.: May 17, 2000). The Congressional Commission on Servicemembers and Veterans Transition Assistance also reported that opportunities exist for greater sharing and partnering between VA and DOD. See *Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance* (Washington, D.C.: Jan. 14, 1999).

VA faces difficult challenges when attempting to improve service delivery efficiencies. For example, service consolidations can have significant ramifications for stakeholders, such as medical schools and unions, primarily due to shifting of workload among locations and workforce reductions. Understandably, medical schools are reluctant to change long-standing business relationships involving, among other things, training of medical residents. For example, VA tried for 5 years to reach agreement on how to consolidate clinical services at two of Chicago's four major health care delivery locations before succeeding in August 2002. This is because such restructuring required two medical schools to use the same location to train residents, a situation that neither supported.

Unions, too, have been reluctant to support planning decisions that result in a restructuring of services. This is because operating efficiencies that result from the consolidation of clinical services into a single location could also result in staffing reductions for such support services as grounds maintenance, food preparation, and housekeeping. For example, as part of its ongoing transformation, VA proposed to consolidate food preparation services of 9 delivery locations into a single location in New York City in order to operate more efficiently. Two union's objections, however, slowed VA's restructuring, although VA and the unions subsequently agreed on a way to complete the restructuring.

VA also faces difficult decisions concerning the need for and sizing of capital investments, especially in locations where future workload may increase over the short term before steadily declining. In large part, such declines are attributable to the expected nationwide decrease in the overall veteran population by more than one-third by 2030; in some areas, veteran population declines are expected to be steeper. It may be in VA's best interests to partner with other public or private providers for services to meet veterans' demands rather than risk making a major capital investment over the long term that would be underutilized in the latter stages of its useful life.

In cases when VA's realignment results in buildings that are no longer needed to meet veterans' health care needs, VA faces other difficult decisions regarding whether to retain or dispose of these buildings. VA has several options, including leasing, demolition, or transferring buildings to the General Services Administration (GSA), which has the authority to dispose of excess or surplus federal property. When there is no leasing potential, VA faces potentially high demolition costs as well as uncertain site preparation costs associated with the transfer of buildings to GSA. Given that such costs involve the use of health care resources, ensuring that disposal decisions are based on systematic analyses of costs and benefits to veterans poses another realignment challenge.<sup>17</sup>

The challenge of dealing with a misaligned infrastructure is not unique to VA. In fact, we identified federal real property management as a high-risk area in January 2003. For the federal government overall and VA in particular, technological advancements, changing public needs, opportunities for resource sharing, and security concerns will call for a new way of thinking about real property needs. In VA's case, it has recognized the critical need to better manage its buildings and land and is in the process of implementing CARES to do so. VA has the opportunity to lead other federal agencies with similar real property challenges. However, VA and other agencies have in common persistent problems, including competing stakeholder interests in real property decisions. Resolving these problems will require high-level attention and effective leadership.

### **Patient Support Services Could Be Provided More Efficiently**

As VA continues to transform itself from an inpatient- to an outpatient-based health care system, it must find more efficient, systemwide ways of providing patient care support services, such as consolidation of services and the use of competitive sourcing. For example, VA's shift in emphasis from inpatient to outpatient health care delivery has significantly reduced the need for inpatient care support services, such as food and

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<sup>17</sup>U.S. General Accounting Office, *VA Health Care: Improved Planning Needed for Management of Excess Real Property*, GAO-03-326 (Washington, D.C.: Jan. 29, 2003).

laundry services. To make better use of resources, some VA inpatient facilities have consolidated food production locations, used lower-cost Veterans Canteen Service (VCS) workers instead of higher-paid Nutrition and Food Service workers<sup>18</sup> to provide inpatient food services, or contracted out for the provision of these services. Some VA facilities have also consolidated two or more laundries into a single location, contracted for labor to operate VA laundries, or contracted out laundry services to commercial organizations.

VA needs to systematically explore the further use of such options across its health care system. In November 2000, we recommended that VA conduct studies at all of its food and laundry service locations to identify and implement the most cost-effective way to provide these services at each location.<sup>19</sup> At that time, we identified 63 food production locations that could be consolidated into 29, saving millions of dollars annually. We estimated that VA could potentially save millions of dollars by consolidating both food and laundry production locations.

VA may also be able to reduce its food and laundry service costs at some facilities through competitive sourcing—through which VA would determine whether it would be more cost-effective to contract out these services or provide them in-house. VA must ensure, however, that, if a decision to contract for services is made, contract terms on payments and service quality standards will continue to be met. For example, we found that weaknesses in the monitoring of VA’s Albany, New York laundry contract appear to have resulted in overpayments, reducing potential savings.<sup>20</sup>

In August 2002, VA issued a directive establishing policy and responsibilities for its networks to follow in implementing a competitive sourcing analysis to compare the cost of contracting and the cost of in-house performance to determine who can do the work most cost effectively. VA has announced that, as part of the President’s Management

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<sup>18</sup> The wage differences between the two result from differences in how wage rates for their respective pay schedules are determined.

<sup>19</sup>U.S. General Accounting Office, *VA Health Care: Expanding Food Service Initiatives Could Save Millions*, GAO-01-64 (Washington, D.C.: Nov. 30 2000); *VA Laundry Service: Consolidations and Competitive Sourcing Could Save Millions*, GAO-01-61 (Washington, D.C.: Nov. 30, 2000).

Agenda, it will complete studies of competitive sourcing of 55,000 positions by 2008. VA plans to complete studies of competitive sourcing for all its laundry positions by the end of calendar year 2003. Similar initiatives for food services and other support services are in the planning stages at VA. Overall, VA's plan for competitive sourcing shows promise. However, VA has not yet established a timeline for implementing an assessment of competitive sourcing and the other options we recommended for all its inpatient food service locations. Until VA completes these assessments and takes action to reduce costs, it may be paying more for inpatient food services than required and as a result have fewer resources available for the provision of health care to veterans.

We recognize that one of the options we recommended that VA assess, the competitive sourcing process set forth in the Office of Management and Budget (OMB) Circular A-76, historically has been difficult to implement. Specifically, there are concerns in both the public and private sectors regarding the fairness of the competitive sourcing process and the extent to which there is a "level playing field" for conducting public-private competitions. It was against this backdrop that the Congress in 2001, mandated that the Comptroller General establish a panel of experts to study the process used by the government to make sourcing decisions. The Commercial Activities Panel that the Comptroller convened conducted a yearlong study, and heard repeatedly about the importance of competition and its central role in fostering economy, efficiency, and continuous performance improvement. The panel made a number of recommendations for improving sourcing policies and processes.

As part of the administration's efforts to implement the recommendations of the Commercial Activities Panel, OMB published proposed changes to Circular A-76 for public comment in November 2002. In our comments on the proposal to the Director of OMB this past January, we noted the absence of a link between sourcing policy and agency missions, unnecessarily complicated source selection procedures, certain unrealistic time frames, and insufficient guidance on calculating savings. The

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<sup>20</sup> U.S. General Accounting Office, *Inadequate Oversight of Laundry Facility at the Department of Veterans Affairs; Albany, New York, Medical Center*, GAO-01-207R (Washington, D.C.: Nov. 30, 2000).

administration is now considering those and other comments as it finalizes the revisions to the Circular.

## **FUNDAMENTAL CHANGES COULD IMPROVE EFFECTIVENESS OF VA'S DISABILITY PROGRAMS**

Significant program design and management challenges hinder VA's ability to provide meaningful and timely support to disabled veterans and their families. VA relies on outmoded medical and economic disability criteria. VA also has difficulty providing veterans with accurate, consistent, and timely benefit decisions, although recent actions have improved timeliness.

### **VA's Disability Criteria Are Outmoded**

In assessing veterans' disabilities, VA remains mired in concepts from the past. VA's disability programs base eligibility assessments on the presence of medically determinable physical and mental impairments. However, these assessments do not always reflect recent medical and technological advances, and their impact on medical conditions that affect the ability to work. VA's disability programs remain grounded in an approach that equates certain medical impairments with the incapacity to work. Moreover, advances in medicine and technology have reduced the severity of some medical conditions and allowed individuals to live with greater independence and function more effectively in work settings. Also, VA's rating schedule updates have not incorporated advances in assistive technologies—such as advanced wheelchair design, a new generation of prosthetic devices, and voice recognition systems—that afford some disabled veterans greater capabilities to work.

VA has made some progress in updating its rating schedule to reflect medical advances. Revisions generally consist of (1) adding, deleting, and reorganizing medical conditions in the *Schedule for Rating Disabilities*, (2) revising the criteria for certain qualifying conditions, and (3) wording changes for clarification or reflection of current medical terminology. However, VA's effort to update its disability criteria within the context of

current program design has been slow and is insufficient to provide the up-to-date criteria VA needs to ensure meaningful and equitable benefit decisions. Completing an update of the schedule for one body system has generally taken 5 years or more; the schedule for the ear and other sense organs took 8 years. In August 2002,<sup>21</sup> we recommended that VA use its annual performance plan to delineate strategies for and progress in updating its disability rating schedule. VA did not concur with our recommendation because it believes that developing timetables for future updates to the rating schedule is inappropriate while the initial review is ongoing.

In addition, VA's disability criteria have not kept pace with changes in the labor market. The nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service- and knowledge-based employment. These changes have affected the skills needed to perform work and the settings in which work occurs. For example, advancements in computers and automated equipment have reduced the need for physical labor. However, the percentage ratings used in VA's *Schedule for Rating Disabilities* are primarily based on physicians' and lawyers' estimates made in 1945 about the effects that service-connected impairments have on the average individual's ability to perform jobs requiring manual or physical labor. VA's use of a disability schedule that has not been modernized to account for labor market changes raises questions about the equity of VA's benefit entitlement decisions; VA could be overcompensating some veterans, while under-compensating—or denying compensation entirely—to others.

In January 1997, we suggested that the Congress consider directing VA to determine whether the ratings for conditions in the schedule correspond to veterans' average loss in earnings due to these conditions and adjust disability ratings accordingly. Our work demonstrated that there were generally accepted and widely used approaches to statistically estimate the effect of specific service-connected conditions on potential

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<sup>21</sup> U.S. General Accounting Office, *SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity*, GAO-02-597 (Washington, D.C.: Aug. 9, 2002).

earnings. These estimates could be used to set disability ratings in the schedule that are appropriate in today's socio-economic environment.<sup>22</sup>

In August 2002, we recommended that VA use its annual performance plan to delineate strategies for and progress in periodically updating labor market data used in its disability determination process. VA did not concur with our recommendation because it does not plan to perform an economic validation of its disability rating schedule, or to revise the schedule based on economic factors. According to VA, the schedule is medically based; represents a consensus among stakeholders in the Congress, VA, and the veteran community; and has been a valid basis for equitably compensating disabled veterans for many years.

Even if VA's schedule updates were completed more quickly, they would not be enough to overcome program design limitations in evaluating disabilities. Because of the limited role of treatment in VA disability programs' statutory and regulatory design, its efforts to update the rating schedule would not fully capture the benefits afforded by treatment advances and assistive technologies. Current program design limits VA's ability to assess veterans' disabilities under corrected conditions, such as the impact of medications on a veteran's ability to work despite a severe mental illness. In August 2002, we recommended that VA study and report to the Congress on the effects that a comprehensive consideration of medical treatment and assistive technologies would have on its disability programs' eligibility criteria and benefit package. This study would include estimates of the effects on the size, cost, and management of VA's disability programs and other relevant VA programs; and would identify any legislative actions needed to initiate and fund such changes. VA did not concur with our recommendation because it believes this would represent a radical change from the current programs, and it questioned whether stakeholders in the Congress and the veterans' community would accept such a change.

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<sup>22</sup> U.S. General Accounting Office, *VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses*, GAO/HEHS-97-9 (Washington, D.C.: Jan. 7, 1997).

VA's disability program challenges are not unique. For example, the Social Security Administration's (SSA) disability programs<sup>23</sup> remain grounded in outmoded concepts of disability. Like VA, SSA has not updated its disability criteria to reflect the current state of science, medicine, technology and labor market conditions. Thus, SSA also needs to reexamine the medical and vocational criteria it uses to determine whether individuals are eligible for benefits.

### **VA Is Trying to Improve the Quality and Timeliness of Claims Processing**

Even if VA brought its disability criteria up to date, it would continue to face challenges in ensuring quality and timely decisions, including ensuring that veterans get consistent decisions—that is, comparable decisions on benefit entitlement and rating percentage—regardless of the regional office making the decisions. VA has made some progress in improving disability program administration, but much remains to be done before VA has a system that can sustain production of accurate, consistent, and timely decisions.

VA is making changes that will allow it to better identify accuracy problems at the national, regional office, and individual employee levels. In turn, this will allow VA to identify underlying causes of inaccuracies and target corrective actions, such as additional training. In response to our March 1999 recommendation,<sup>24</sup> VA has centralized accuracy reviews under its Systematic Technical Accuracy Review (STAR) program to meet generally applicable government standards on segregation of duties and organizational independence. Also, the STAR program began reviewing more decisions in fiscal year 2002, with the intent of obtaining statistically valid accuracy data at the regional office level; regional office-level accuracy goals have been incorporated into regional directors' performance standards. Further, VA is developing a system to

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<sup>23</sup> Disability Insurance (DI) provides benefits to workers with severe long-term disabilities who have enough work history to be insured for coverage under the program. Supplemental Security Income (SSI) provides benefits to disabled, blind, or aged individuals with low income and limited resources, regardless of their work histories.

<sup>24</sup> U.S. General Accounting Office, *Veterans' Benefits Claims: Further Improvements Needed in Claims-Processing Accuracy*, GAO/HEHS-99-35 (Washington, D.C.: Mar. 1, 1999).

measure the accuracy of individual employees' work; this measurement is tied to employee performance evaluations.

While VA has made changes to improve accuracy, it continues to face challenges in ensuring consistent claims decisions. In August 2002, we recommended that VA establish a system to regularly assess and measure the degree of consistency across all levels of VA claims adjudication.<sup>25</sup> While VA agreed that consistency is an important goal, it did not fully respond to our recommendation regarding consistency because it did not describe how it would measure consistency and evaluate progress in reducing any inconsistencies it may find. Instead, VA said that consistency is best achieved through comprehensive training and communication among VA components involved in the adjudication process. We continue to believe that VA will be unable to determine the extent to which such efforts actually improve consistency of decision-making across all levels of VA adjudication now and over time.

VA's major focus over the past 2 years has been on producing more timely decisions for veterans, and it has made significant progress in improving timeliness and reducing the backlog of claims. The Secretary established the VA Claims Processing Task Force, which in October 2001 made specific recommendations to relieve the veterans' claims backlog and make claims processing more timely. The task force observed that the work management system in many regional offices contributed to inefficiency and an increased number of errors. The task force attributed these problems primarily to the broad scope of duties performed by regional office staff—in particular, veterans service representatives (VSR). For example, VSRs were responsible for both collecting evidence to support claims and answering claimants' inquiries. Based on the task force's recommendations, VA implemented its claims process improvement (CPI) initiative in fiscal year 2002. Under this initiative, regional office claims processing operations were reorganized around specialized teams to handle specific stages of the claims process. For example,

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<sup>25</sup> U.S. General Accounting Office, *Veterans' Benefits: Quality Assurance for Disability Claims and Appeals Processing Can Be Further Improved*, GAO-02-806 (Washington, D.C.: Aug. 16, 2002).

regional offices have teams devoted specifically to claims development, that is, obtaining evidence needed to evaluate claims.

Also, VA focused on increasing production of rating-related decisions to help reduce inventory and, in turn, improve timeliness. In fiscal years 2001 and 2002, VA hired and trained hundreds of new claims processing staff. VA also set monthly production goals for fiscal year 2002 for each of its regional offices, incorporating these goals into regional office directors' performance standards. VA completed almost as many decisions in the first half of 2003 (404,000) than in all of fiscal year 2001 (481,000). This increase in production has contributed to a significant inventory reduction; on March 31, 2003, the rating-related inventory was about 301,000 claims, down from about 421,000 at the end of fiscal year 2001. Meanwhile, rating-related decisions timeliness has been improving recently; an average of 199 days for the first half of fiscal year 2003, down from an average of 223 days in fiscal year 2002.

While VA has made progress in getting its workload under control and improving timeliness, it will be challenged to sustain this performance. Moreover, it will be difficult to cope with future workload increases due to factors beyond its control, such as future military conflicts, court decisions, legislative mandates, and changes in the filing behavior of veterans. VA is not alone in facing these challenges; SSA is also challenged to improve its ability to provide accurate, consistent, and timely disability decisions to program applicants. For example, after failing in its attempts since 1994 to redesign a more comprehensive quality assurance system, SSA has recently begun a new quality management initiative. Also, SSA has taken steps to provide training and enhance communication to improve the consistency of decisions, but variations in allowances rates continue and a significant number of denied claims are still awarded on appeal. SSA has recently implemented several short-term initiatives not requiring statutory or regulatory changes to reduce processing times but is still evaluating strategies for longer-term solutions.

More dramatic gains in timeliness and inventory reduction might require program design changes. For example, in 1996, the Veterans' Claims Adjudication Commission noted that most disability compensation claims are repeat claims—such as claims for increased disability percentage—and most repeat claims were from veterans with less severe disabilities. The Commission questioned whether concentrating processing resources on these claims, rather than on claims by more severely disabled veterans, was consistent with program intent. Another possible program design change might involve assigning priorities to the processing of claims. For example, claims from veterans with the most severe disabilities and combat-disabled veterans could receive the highest priority attention. Program design changes, including those to address the Commission's concerns, might require legislative actions.

In addition to program design changes, outside studies of VA's disability claims process identified potential advantages to restructuring VA's system of 57 regional offices. In its January 1999 report, the Congressional Commission on Servicemembers and Veterans Transition Assistance stated that some regional offices might be so small that their disproportionately large supervisory overhead unnecessarily consumes personnel resources. Similarly, in its 1997 report, the National Academy of Public Administration stated VA should be able to close a large number of regional offices and achieve significant savings in administrative overhead costs.

Apart from the issue of closing regional offices, the Commission highlighted a need to consolidate disability claims processing into fewer locations. VA has consolidated its education assistance and housing loan guaranty programs into fewer than 10 locations, and the Commission encouraged VA to take similar action in the disability programs. VA proposed such a consolidation in 1995 and in that proposal enumerated several potential benefits, such as allowing VA to assign the most experienced and productive adjudication officers and directors to the consolidated offices; facilitating increased specialization and as-needed expert consultation in deciding complex cases; improving the completeness of claims development, the accuracy and consistency of rating decisions, and the clarity of decision explanations; improving overall adjudication quality by increasing the pool of experience and expertise in critical technical areas; and facilitating consistency in

decisionmaking through fewer consolidated claims-processing centers. VA has already consolidated some of its pension workload (specifically, income and eligibility verifications) at three regional offices.<sup>26</sup> Also, VA has consolidated at its Philadelphia regional office dependency and indemnity compensation claims by survivors of servicemembers who died on active duty, including those who died during Operation Enduring Freedom and Operation Iraqi Freedom.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

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#### Contact and Acknowledgments

For further information, please contact me at (202) 512-7207. Individuals making key contributions to this testimony include Paul R. Reynolds, James C. Musselwhite, Jr., Irene P. Chu, Pamela A. Dooley, Cherie' M. Starck, William R. Simerl, Richard J. Wade, Thomas A. Walke, Cheryl A. Brand, Kristin M. Wilson, Greg Whitney, and Daniel Montinez.

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<sup>26</sup> These are the VA regional offices in St. Paul, Minnesota; Philadelphia, Pennsylvania; and Milwaukee, Wisconsin.

## **Related GAO Products**

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*VA Health Care: Improved Planning Needed for Management of Excess Real Property.* GAO-03-326. Washington, D.C.: January 29, 2003.

*High-Risk Series: An Update.* GAO-03-119. Washington, D.C.: January 2003.

*High-Risk Series: Federal Real Property.* GAO-03-122. Washington, D.C.: January 2003.

*Major Management Challenges and Program Risks: Department of Veterans Affairs.* GAO-03-110. Washington, D.C.: January 2003.

*Veterans' Benefits: Quality Assurance for Disability Claims and Appeals Processing Can Be Further Improved.* GAO-02-806. Washington, D.C.: August 16, 2002.

*SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity.* GAO-02-597. Washington, D.C.: August 9, 2002.

*VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven.* GAO-02-652T. Washington, D.C.: April 25, 2002.

*VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven.* GAO-02-510R. Washington, D.C.: March 29, 2002.

*VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress.* GAO-01-953. Washington, D.C.: August 31, 2001.

*VA Health Care: Community-Based Clinics Improve Primary Care Access.* GAO-01-678T. Washington, D.C.: May 2, 2001.

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*Veterans' Health Care: VA Needs Better Data on Extent and Causes of Waiting Times.* GAO/HEHS-00-90. Washington, D.C.: May 31, 2000.

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*VA Health Care: Challenges Facing VA in Developing an Asset Realignment Process.* GAO/T-HEHS-99-173. Washington, D.C.: July 22, 1999.

*Veterans' Affairs: Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act.* GAO/T-HEHS-99-125. Washington, D.C.: May 19, 1999.

*Veterans' Affairs: Progress and Challenges in Transforming Health Care.* GAO/T-HEHS-99-109. Washington, D.C.: April 15, 1999.

*VA Health Care: Capital Asset Planning and Budgeting Need Improvement.* GAO/T-HEHS-99-83. Washington, D.C.: March 10, 1999.

*Veterans' Benefits Claims: Further Improvements Needed in Claims-Processing Accuracy.* GAO/HEHS-99-35. Washington, D.C.: March 1, 1999.

*VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services.* GAO/HEHS-98-64. Washington, D.C.: April 16, 1998.

*VA Hospitals: Issues and Challenges for the Future.* GAO/HEHS-98-32. Washington, D.C.: April 30, 1998.

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*VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses.* GAO/HEHS-97-9. Washington, D.C.: January 7, 1997.

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